STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	07/19/2012

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COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

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F0000	This visit was for the investigation of Complaint IN00111127. Complaint IN00111127-Substantiated, Federal/State deficiencies related to the allegations are cited at F 279, F 282, F323, and F 513. Survey dates: 7/17, 18, 19, 2012 Facility number: 000476 Provider number: 155446 Aim number: 100290870 Survey team: Ann Armey, RN TC Ellen Ruppel, RN Census bed type: SNF/NF: 125 Total: 125 Census payor type: Medicare: 21 Medicaid: 73 Other: 31 Total: 125 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed 7/24/12 Cathy Emswiller RN			

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F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to develop a care plan to address smoking safety. This deficiency affected 1 of 3 residents reviewed, who smoked at the facility, in a sample of 8. (Resident #E) Findings include: On 7/17/12 at 9:15 a.m., during the entrance conference, the Administrator indicated there had been an incident on 7/15/12 and Resident #E had been burned on the hand while smoking in an outdoor	F0279	A Smoking Safety Assessment and a Smoking Risk Care Plan was completed on 7/16/12 for Resident E. While developing the plan of care for Resident E, it was determined that Resident E would need a smoking apron to facilitate safe smoking. The smoking apron arrived on 7/18/2012 from a sister facility. Resident E is part of Safe Smoking Program were oxygen use is prohibited , adaptive equipment is monitored, and supervision is provided during the smoking periods. All residents identified with the desire to smoke had the Smoking Safety Assessment**(Attachment**	08/18/2012

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	smoking area. The Administrator indicated the incident was not witnessed by facility staff but had been reported later to facility staff by a peer who had witnessed the incident. The Administrator indicated, after the incident, all resident who smoke, were reassessed and their care plans were reviewed. The Administrator indicated the smoking policy was revised, a schedule of designated smoking times was initiated, residents were educated regarding the need to keep smoking materials with licensed nursing staff and residents were now monitored during smoking sessions. On 7/17/12 at 9:30 a.m., Resident #E was observed in her wheelchair in her room. Her left hand was bandaged and she was asked about the injury to the hand. The resident indicated it happened just like that and she snapped her finger. Resident #E indicated she could not reach the portable oxygen control that was on the back of her wheelchair, so after the spark, she yanked the nasal canula tubing so it wasn't connected to the oxygen tank. The resident indicated she smoked independently and it was usual for her to have her oxygen with her when she went out to smoke. She indicated she would take the nasal canula off and hang it on the wheelchair while she was smoking.		**A)** and Smoking Risk Care Plan **(Attachment B)** reevaluated. A formal letter was sent to all resident representatives, to educate them on the importance of not providing smoking matrials directly to the resident **(Attachment C)**. Every smoker will follow the Safe Smoking Guidelines and sign a Release and Disclosure of Smoking Risks **(Attachment D)**. The facility put into place a Safe Smoking Program. All residents must be accompanied by the designated staff member during the scheduled smoking times. The smoking times occur every two hours from the hours of 9:00am to 9:00pm. In addition, the staff member responsible for monitoring the residents, must complete the Smoking Check-Off (**Attachment E)** In-servicing was provided to all staff members regarding the changes with resident smoking **(Attachment F)**. The Smoking Check-Off will be given to the Director of Nursing for review. All Smoking Safety Assessments and Smoking Risk Care Plans will be reviewed by the Interdisciplinary Team on a quarterly, annual and significant change basis. A resident with the preference of smoking, will be maintained on an auditing spreadsheet to ensure the assessments are completed in a timely manner **(Attachment G)**. The Director of Nursing will	

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	On 7/17/12 at 4:45 p.m., Resident #J, who witnessed and reported the incident, was interviewed. The resident indicated Resident #E had her oxygen tubing in her lap and there was a flame. Resident #J said she told Resident #E to throw the tubing on the ground but Resident #E patted the flame with her hand and jerked the tubing out of the oxygen container. On 7/18/12 at 1:30 p.m. LPN #11, who worked on Resident #E's hall was interviewed. She indicated Resident #E went out with her oxygen to smoke. The LPN indicated Resident #E had been told not to do this but the resident smoked independently and had her own supplies so it was difficult to monitor her. The clinical record of Resident #E was reviewed on 7/17/12 at 1:50 p.m. and indicated the resident was admitted to the facility on 4/16/12, with diagnoses which included and were not limited to, chronic obstructive pulmonary disease and schizophrenia. The Admission Nursing Assessment, dated 4/16/12, indicated the resident did not desire to smoke and as a result no additional assessment was done. Physician orders, dated 4/21/12, indicated		maintain this spreadsheet. In addition, any discrepencies found within the Smoking Check-Off and Smoking Assessmen Audit spreadsheet will have immediate corrective action and discussed at the monthly QA&A meeting to further identify any changes needed to the program.	

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	the resident was to receive oxygen at 3 liters per nasal canula continuously. The MDS (Minimum Data Set) Assessment, dated 6/14/12, indicated the resident had no cognitive impairments, required supervision of one staff for transfer/locomotion/toileting, required extensive assistance with dressing and did not ambulate during the 7-day observation period. On 7/15/12 at 10:30 a.m., nursing notes indicated "has 1st degree burn to left palm of hand. Redness noted. Denies pain or discomfort. Area cooled w/cold water; Bacitrin (sic) & (and) bandage applied. Res (resident) refused to state what happened; peers report that res (resident) outside smoking c (with) O2 (oxygen) portable O2 tank. Res (Resident) has been told multiple times by nurses & (and) aides to take tank off before going outside to smoke. (Physician's Name) notified. Resident own POA (Power of Attorney). On 7/15/12 at 10:10 p.m., nursing notes indicated Resident #E's left hand was observed at 8:30 p.m. and she had four fluid filled blisters. On 7/16/12 at 2:30 p.m. nursing notes indicated the resident had four fluid filled			

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	blisters to palm/fingers and an open blister to the crease of the thumb on the left hand measuring as follows: 1.8 cm by 1.4 cm; 0.9 cm by 0.8 cm; 1.1 cm by 0.5 cm; 1.5 cm by 1.3 cm; and 1.7 cm by 1.8 cm There was no documentation a smoking safety care plan was completed until, after the incident, on 7/16/12. The Smoking Safety Assessment, dated 7/16/12, indicated the resident was a potentially unsafe smoker and "must be supervised and wear a protective non-flammable cover (smoking apron) when smoking." The Smoking Risk Care Plan, dated 7/16/12, indicated the following: educate/enforce smoking in designated areas only, review smoking safety quarterly, provide information on smoking cessation as desired, provide safe receptacles for extinguishing ashes, reinforce safe practices, praise safe practices, staff to retain cigarettes, staff to retain lighters, and supervised smoking.			

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	Although the assessment indicated the resident must wear a smoking apron, there was no mention of the apron in the care plan. Resident #E was observed during smoking sessions on 7/17/12 at 11:00 a.m., at 7/17/12 at 3:00 p.m. and 7/18/12 at 9:00 a.m. Resident #E was being monitored by staff, the oxygen was removed prior to smoking, and smoking material were provided by staff. The outside smoking area had a fire extinguisher, a water thermos, and a safety ash receptacle. Resident #E did not wear an apron during the smoking sessions observed. On 7/17/12 at 4:00 p.m., the Administrator indicated they were unable to locate a smoking assessment or a smoking care plan for the resident prior to the incident. On 7/18/12 at 11:00 a.m., the Administrator indicated and smoking aprons had been ordered on 7/16/12 but had not yet been delivered, smoking aprons were being obtained from a sister facility and would be delivered on 7/18/12. The Smoking Policy, revised October			

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	2009, that was in place prior to the incident on 7/15/12, provided by the administrator, was reviewed on 7/17/12 at 2:00 p.m. and indicated in part, "It is the policy to monitor and evaluate residents for safety related to smoking...The Interdisciplinary Team (IDT) is responsible for ensuring safety risks are evaluated, and that smoking is conducted in a safe manner... 1. The IDT will evaluate safety, physical ability, sensory issues, and the need for adaptive or safety equipment upon admission, with every significant change... and annually for resident's who express a desire to smoke. 2. Staff will control distribution of all cigarettes and lighting materials for all residents,... 3. For residents who have been determined to need supervised smoking, or are unsafe when smoking, staff will provide appropriate supervision... a. Use of adaptive equipment (smoking aprons, etc.)..... 5. Portable oxygen tanks and/or other O2 delivery systems are not allowed in designated smoking areas, even if oxygen is turned off. 6. Residents who do not adhere to facility smoking protocols and rules should be reviewed for alternate placement..... Care Plan Documentation Guidelines.... Identify measurable goals for safe			

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	smoking... List approaches to monitor and prevent complications." This Federal tag relates to Complaint IN00111127. 3.1-35(b)(1)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to assure treatments were done as ordered. This deficiency affected 1 of 3 residents reviewed, who received treatments in a sample of 8. (Resident #D) Findings include: On 7/17/12 at 9:45 a.m., during the entrance tour, MR (Medical Records) Staff Person #10 indicated Resident #D had bilateral pressure areas on her heels. The clinical record of Resident #D was reviewed on 7/17/12 at 3:20 p.m., and indicated the resident was admitted to the facility on 2/7/12, with diagnoses which included but were not limited to, cerebral vascular accident (stroke) with left sided weakness and insulin dependent diabetes mellitus. The MDS (Minimum Data Set) Assessment, dated 5/16/12, indicated Resident #D had no cognitive impairments and required extensive	F0282	A meeting was held to reeducate the nurses on the double check system in place to identifying completion of all treatments. From the nurse's meeting notes, "During shift change the out-going and in-coming nurses must review the MAR/TAR for any holes indicating the potential for incomplete treatments".A meeting was held to reeducate the nurses on the double check system in place to identifying completion of all treatments. From the nurse's meeting notes, "During shift change the out-going and in-coming nurses must review the MAR/TAR for any holes indicating the potential for incomplete treatments".At shift changet, the incoming and outgoing nurse will review the MAR/TAR for any missed signature indicating the treatment was not completed. The incoming and outing nurse must both sign the Verification of Review of MAR/TAR During Shift Change document indicating this process was completed **(Attachment H)**.The Unit Manager will review the document daily and discuss any defiecencies in the daily Clincial Meeting. In addition, the Verification of Review of	08/18/2012

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	assistance with transfer, dressing and hygiene. On 6/19/12, a Pressure Evaluation Record indicated two areas were identified on Resident #D's left heel, measuring 4.8 cm by 4.6 cm and on her left great toe, measuring 2.4 cm by 2.2 cm. The record listed the stage of the areas as UTD (Unable to Determine/Unstageable) and indicated the left heel wound bed was covered with 100 % slough while the left great toe wound bed was covered with 50 % slough. On 6/19/12, the Physician was notified and the following was ordered: Santyl/Bactroban mix to left heel twice daily and cover with a clean dry dressing; Bactroban to the left great toe and cover with clean dry dressing every day; Doxycycline (an antibiotic medication) 100 mg twice daily for 10 days; Vitamin C 500 mg every day; Zinc Sulfate 220 mg every day; Complete Blood Count, Albumin, and Total Protein laboratory tests; and A Doppler ultrasound of the left lower leg. On 6/21/12, the resident was examined by the Wound Physician. The Wound Care Specialist Report indicated a third unstageable area was noted on the right		MAR/TAR During Shift Change completed verification document will be forwarded to the Director of Nursing weekly for review and filing. If signatures are missed, indicating the review was not completed, both the incoming and outgoing nurse will be held responsible for any error. Corrective action and reeducation will result, e nforced by the Unit Manager and/or Director of Nursing. Results will be submitted to the QA committee monthly for at least three moonths for review and recommendations; this monitoring will continue until no issues are identified for a three month period.	

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	heel, measuring 5.0 cm by 4.5 cm. On 6/21/12, the Physician ordered Crowfoots and a bilateral lower leg arterial Doppler ultrasound. The treatments were changed to cleanse the left heel, right heel, and left toe with normal saline, apply skin prep topically and cover with a dry dressing every day. On 6/28/12, the frequency of the treatments to the left heel, left toe, and right heel were increased to twice daily by the Wound Physician. On 7/6/12, physician's orders indicated the treatment to the left heel was changed to Santyl/Bactroban mix and cover with foam every day. The treatments to right heel and left toe were unchanged (cleanse with normal saline and apply skin prep with a clean dry dressing twice daily). On 7/12/12, the Wound Care Specialist Evaluation indicated the areas on the left heel and right heel were improving. On 7/18/12 at 2:00 p.m., the wounds on Resident #D's feet were observed. The Wound Nurse, measured the wounds and found them to be, as follows: left heel, 4.3 cm by 6 cm., covered with an eschar cap that was pulling away from			

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	the edges of the heel; right heel, 2.8 cm by 1.7 cm, and left toe, 1.6 cm by 1.2 cm.. The areas on the right heel and left toe were dry and healing. On 7/18/12 at 2:15 p.m., Resident #D was interviewed. She indicated the facility provided her with a specialized air loss mattress but she did not like the movement of the mattress and asked that it be removed. She indicated she did not like to wear her specialized boots and pillows were placed under her lower legs when she was in bed. Resident #D further indicated that her treatment was to be done twice daily but was not always done on the evening shift. There was no documentation, on the July 2012 MAR (Medication Administration Record), that the twice daily treatment was done in the evening on three of sixteen days (7/9,11,12/12). On 7/9/12 and 7/12/12 there were blanks in the area where the evening treatment should have been documented and on 7/11/12 the treatment was circled as not done, with no explanation. On 7/18/12 at 2:10 p.m., the ADON indicated she was not able to determine if the evening treatments on 7/9/12/12, 7/11/12 and 7/12/12 were done.			

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	The Pressure Ulcer, Prevention Policy, dated 2006, provided by the Administrator, was reviewed on 7/19/12, and indicated, in part, "...If a pressure ulcer is present, the licensed nurse is responsible to record the condition of the skin,...as well as the treatment provided..." This Federal tag relates to Complaint IN00111127. 3.1-35(g)(2)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the safety of a resident, who was smoking in an outdoor smoking area and failed to prevent oxygen usage in a smoking area. This resulted in a resident being burned. This deficiency affected 1 of 3 residents reviewed, who smoked at the facility, in a sample of 8. (Resident #E) Findings include: On 7/17/12 at 9:15 a.m., during the entrance conference, the Administrator indicated there had been an incident on 7/15/12 and Resident #E had been burned on the hand while smoking in an outdoor smoking area. The Administrator indicated the incident had not been witnessed by facility staff but had been reported later to facility staff by a peer who had witnessed the incident. The Administrator indicated, after the incident, all resident who smoke, were reassessed and their care plans were reviewed. The Administrator indicated the smoking policy was revised, a schedule of	F0323	A Smoking Safety Assessment and a Smoking Risk Care Plan was completed on 7/16/12 for Resident E. While developing the plan of care for Resident E, it was determined that Resident E would need a smoking apron to facilitate safe smoking. The smoking apron arrived on 7/18/2012 from a sister facility. Resident E is part of Safe Smoking Program were oxygen use is prohibited , adaptive equipment is monitored, and supervision is provided during the smoking periods. All residents identified with the desire to smoke had the Smoking Safety Assessment**(Attachment A)** and Smoking Risk Care Plan **(Attachment B)** reevaluated. A formal letter was sent to all resident representatives, to educate them on the importance of not providing smoking matrials directly to the resident **(Attachment C)**. Every smoker will follow the Safe Smoking Guidelines and sign a Release and Disclosure of Smoking Risks **(Attachment D)**. The facility put into place a Safe Smoking Program. All residents must be accompanied by the designated staff member during	08/18/2012

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	155446	A. BUILDING 00 B. WING	07/19/2012

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	designated smoking times was initiated, residents were educated regarding the need to keep smoking materials with licensed nursing staff and residents were now monitored during smoking sessions. On 7/17/12 at 9:30 a.m., Resident #E was observed in her wheelchair in her room. Her left hand was bandaged and she was asked about the injury to the hand. The resident indicated it happened just like that and she snapped her finger. Resident #E indicated she could not reach the portable oxygen control that was on the back of her wheelchair, so after the spark, she yanked the nasal canula tubing so it wasn't connected to the oxygen tank. The resident indicated she smoked independently and it was usual for her to have her oxygen with her when she went out to smoke. She indicated she would take the nasal canula off and hang it on the wheelchair while she was smoking. On 7/17/12 at 4:45 p.m., Resident #J, who witnessed and reported the incident, was interviewed. The resident indicated Resident #E had her oxygen tubing in her lap and there was a flame. Resident #J said she told Resident #E to throw the tubing on the ground but Resident #E patted the flame with her hand and jerked the tubing out of the oxygen container.		the scheduled smoking times. The smoking times occur every two hours from the hours of 9:00am to 9:00pm. In addition, the staff member responsible for monitoring the residents, must complete the Smoking Check-Off (**Attachment E)** In-servicing was provided to all staff members regarding the changes with resident smoking **(Attachment F)**. The Smoking Check-Off will be given to the Director of Nursing for review. All Smoking Safety Assessments and Smoking Risk Care Plans will be reviewed by the Interdisciplinary Team on a quarterly, annual and significant change basis. A resident with the preference of smoking, will be maintained on an auditing spreadsheet to ensure the assessments are completed in a timely manner **(Attachment G)**. The Director of Nursing will maintain this spreadsheet. In addition, any discrepencies found within the Smoking Check-Off and Smoking Assessmen Audit spreadsheet will have immediate corrective action and discussed at the monthly QA&A meeting to further identify any changes needed to the program.	

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	On 7/18/12 at 1:30 p.m. LPN #11, who worked on Resident #E's hall was interviewed. She indicated Resident #E went out with her oxygen to smoke. The LPN indicated the resident had been told not to do this but she smoked independently and had her own supplies so it was difficult to monitor her. The clinical record of Resident #E was reviewed on 7/17/12 at 1:50 p.m. and indicated the resident was admitted to the facility on 4/16/12, with diagnoses which included and were not limited to, chronic obstructive pulmonary disease and schizophrenia. The Admission Nursing Assessment, dated 4/16/12, indicated the resident did not desire to smoke and as a result no additional assessment was done. Physician orders, dated 4/21/12, indicated the resident was to receive oxygen at 3 liters per nasal canula continuously. The MDS (Minimum Data Set) Assessment, dated 6/14/12, indicated the resident had no cognitive impairments, required supervision of one staff for transfer/locomotion/toileting, required extensive assistance with dressing and did not ambulate during the 7-day			

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	observation period. On 7/15/12 at 10:30 a.m., nursing notes indicated "has 1st degree burn to left palm of hand. Redness noted. Denies pain or discomfort. Area cooled w/cold water; Bacitrin (sic) & (and) bandage applied. Res (resident) refused to state what happened; peers report that res (resident) outside smoking c (with) O2 (oxygen) portable O2 tank. Res (Resident) has been told multiple times by nurses & (and) aides to take tank off before going outside to smoke. (Physician's Name) notified. Resident own POA (Power of Attorney). On 7/15/12 at 10:10 p.m., nursing notes indicated Resident #E's left hand was observed at 8:30 p.m. and she had four fluid filled blisters. On 7/16/12 at 2:30 p.m. nursing notes indicated the resident had four fluid filled blisters to palm/fingers and an open blister to the crease of the thumb on the left hand measuring as follows: 1.8 cm by 1.4 cm; 0.9 cm by 0.8 cm; 1.1 cm by 0.5 cm; 1.5 cm by 1.3 cm; and 1.7 cm by 1.8 cm There was no documentation a smoking			

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	safety assessment or smoking care plan were completed until, after the incident, on 7/16/12. The Smoking Safety Assessment, completed on 7/16/12, indicated the resident was a potentially unsafe smoker and "must be supervised and wear a protective non-flammable cover (smoking apron) when smoking." The Smoking Risk Care plan, dated 7/16/12, indicated the following: educate/enforce smoking in designated areas only, review smoking safety quarterly, provide information on smoking cessation as desired, provide safe receptacles for extinguishing ashes, reinforce safe practices, praise safe practices, staff to retain cigarettes, staff to retain lighters, and supervised smoking. Although the Smoking Safety Assessment indicated the resident must wear a smoking apron, there was no mention of the apron in the care plan. Resident #E was observed during smoking sessions on 7/17/12 at 11:00 a.m., at 7/17/12 at 3:00 p.m. and 7/18/12 at 9:00 a.m.			

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	Resident #E was monitored, the oxygen was removed prior to smoking, and smoking material were provided by staff. The outside smoking area had a fire extinguisher, a water thermos, and a safety ash receptacle. Resident #E did not wear an apron during the smoking sessions observed. On 7/17/12 at 4:00 p.m., the Administrator indicated they were unable to locate a smoking assessment or a smoking care plan for the resident prior to the incident. On 7/18/12 at 11:00 a.m., the Administrator indicated and smoking aprons had been ordered on 7/16/12 but had not yet been delivered, smoking aprons were being obtained from a sister facility and would be delivered on 7/18/12. The Smoking Policy, revised October 2009, that was in place prior to the incident on 7/15/12, provided by the administrator, was reviewed on 7/17/12 at 2:00 p.m. and indicated in part, "It is the policy to monitor and evaluate residents for safety related to smoking...The Interdisciplinary Team (IDT) is responsible for ensuring safety risks are evaluated, and that smoking is conducted in a safe manner...			

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	1. The IDT will evaluate safety, physical ability, sensory issues, and the need for adaptive or safety equipment upon admission, with every significant change... and annually for resident's who express a desire to smoke. 2. Staff will control distribution of all cigarettes and lighting materials for all residents,... 3. For residents who have been determined to need supervised smoking, or are unsafe when smoking, staff will provide appropriate supervision... a. Use of adaptive equipment (smoking aprons, etc.)..... 5. Portable oxygen tanks and/or other O2 delivery systems are not allowed in designated smoking areas, even if oxygen is turned off. 6. Residents who do not adhere to facility smoking protocols and rules should be reviewed for alternate placement..... Care Plan Documentation Guidelines.... Identify measurable goals for safe smoking... List approaches to monitor and prevent complications." This Federal tag relates to Complaint IN00111127. 3.1-45(a)(1) 3.1-45(a)(2)			

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F0513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. Based on interview and record review, the facility failed to have a resident's venous and arterial doppler ultra sound reports in the clinical record. This deficiency affected 1 of 3 residents whose ultrasound reports were reviewed, in a sample of 8. (Resident #D) Findings include: On 7/17/12 at 9:45 a.m., during the entrance tour, MR (Medical Records) Staff Person #10 indicated Resident #D had bilateral pressure areas on her heels. The clinical record of Resident #D indicated the resident was admitted to the facility on 2/7/12 with diagnoses including but not limited to, cerebral vascular accident (stroke) with left sided weakness and insulin dependent diabetes mellitus. On 6/19/12, a Pressure Evaluation Record indicated two unstageable areas were identified on the Resident #D's left heel, measuring 4.8 cm by 4.6 cm and on her left great toe, measuring 2.4 cm by 2.2 cm.	F0513	The arterial and venous Doppler ultrasound was obtain edduring the survey process for the clinical record.The third shift nurse on each unit will be responsible to list all labs and diagnostic test for the day by reviewing the TAR and placing the tests on the form, "Daily Lab and Diagnostic Tests Audit" **(Attachment I)**. The floor nurse will utilize the form to ensure all labs and/or diagnostic test results have been obtained. In addition, the floor nurse will ensure all follow through with the ordering physician has been completed. The Unit Manager will review the "Daily Lab and Diagnostic Test Audit" to spot check all components were completed. The form will be reviewed during the daily Clinical Meeting to identify and discuss any discrepancies. The completed form will be filed on the unit.The Unit Manager will review the document daily and discuss any deficiencies in the daily Clinical Meeting. Corrective action and reeducation will result, enforced by the Unit Manager and/or Director of Nursing. Discrepencies will be reviewed during the QA&A meeting to identify any further changes needed.Results will be submitted	08/18/2012

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	On 6/19/12, the Physician ordered a Venous Doppler ultrasound study of the left lower extremity. On 6/21/12, the resident was examined by the Wound Physician. The Wound Care Specialist Report indicated a third unstageable area was noted on the right heel, measuring 5.0 cm by 4.5 cm. On 6/21/12, the Physician ordered Arterial Doppler ultrasound studies of Resident #D's bilateral lower legs. There was no documentation the ultrasound studies were done. On 7/18/12 at 6:09 a.m., the ultrasound reports, completed on 6/20/12 and 6/22/12 were faxed to the facility. On 7/18/12 at 1:15 p.m., the ADON (Assistant Director of Nursing) indicated the arterial and venous doppler ultra sound reports were not in the clinical record until 7/18/12. This Federal tag relates to Complaint IN00111127. 3.1-49(j)(4)		to the QA committee monthly for at least three moonths for review and recommendations; this monitoring will continue until no issues are identified for a three month period.	

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